Michigan Eye Consultants

Patient's Information:

Name: _____ DOB: _____ Gender: M / F

Address: _____

Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____

Preferred method of communication: Cell Phone / Email / Face to Face / Text Message

Primary Care Physician: _____ Phone: _____

Guardian / Representative's Information (if applicable):

Name: _____ Relationship: _____ Cell Phone: _____

Person(s) authorized to access my health information (name/relationship):

_____

Medical Insurance:

Insurance Name: _____ Subscriber ID: _____

Insured Name: _____ Insured DOB: _____ Relationship to pt: _____

Name of Secondary / Medigap Insurance: _____

NOTICE

- **MEDICAL INSURANCE CO-PAY, REFRACTION, AND OTHER NON-COVERED TREATMENTS/PROCEDURES ARE DUE AT THE TIME OF SERVICE.**
- **MEDICAL INSURANCE DEDUCTIBLE AND CO-INSURANCE ARE DUE AFTER YOUR INSURANCE CLAIM IS PROCESSED – You will receive an electronic and/or a paper invoice with a 30-day term.**
- **ALL BALANCES NEED TO BE PAID IN FULL BEFORE FUTURE APPOINTMENTS CAN TAKE PLACE.**

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Payment Authorization

Thank you for choosing Michigan Eye Consultants (MEC) as your eye care provider. We are committed to providing you with the highest quality of eye care. Please read and sign the following to acknowledge your understanding of our payment policies.

○ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care. MEC will bill the patient's medical insurance for the service. The patient is required to provide the most accurate and updated insurance information. The patient is responsible for the payment of co-pay, deductible, co-insurance, and all other procedures or treatments that are not covered by the patient's medical insurance plan.

○ Co-pay and other non-covered items are due at the time of service.

○ By my signature below, I hereby authorize the assignment of financial benefits directly to Michigan Eye Consultants and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Out-Of-Pocket Costs

MEC is a **MEDICAL OPTOMETRY OFFICE**, and is **In-Network** with major medical insurances and out-of-network with all Vision Plans. Your medical insurance will be utilized if there are medical findings during the examination.

The following are the typical out-of-pocket costs at MEC:

- Eye Health Examination – **$95**
- Enhanced Medical Exam – **$180**
- **Insurance Copay – Ins. Dependent**
- **Deductible & Co-Insurance**
- Refraction (Glasses Rx) – **$40**
- Screening Optomap – **$45**
- Tech Package – **$85**
- Paperwork – **$35**
- Contact Lens Class – **$50**
- CL Fitting – Spherical – **$70**
- CL Fitting – Astigmatism – **$120**
- CL Fitting – Multifocal/Mono – **$130**
- CL Fitting – RGP – **$140**
- Wellness OCT – **$45**
- Punctal Plugs –180 days – **$40**
- Punctal Plugs – Permanent – **$80**

MEDICAL INSURANCE DEDUCTIBLE AND CO-INSURANCE ARE DUE AFTER YOUR INSURANCE CLAIM IS PROCESSED – You will receive an electronic and/or a paper invoice with a 30-day term (*PLEASE ASK OUR ASSOCIATES IF YOU HAVE ANY QUESTIONS.)*

_____	_____	_____
Signature of patient/representative	Name (Pt/Rep)	Date

Michigan Eye Consultants

Privacy Policy

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Use and Disclosures of Health Information
We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us.

Use and Disclosures Based on Your Authorization
Except as stated we will not use or disclose your health information without your written authorization.

Use and Disclosures Not Requiring Your Authorization
In the following circumstances, we may disclose your health information without your written authorization:

- To family members who are involved in your healthcare
- For purposes of public health and safety
- To government agencies for purposes of audits and investigations
- To the FDA to report product defects or incidents
- When required by court orders, search warrants, subpoenas and as required by the law

Patient's Rights
As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of disclosures we have made of your health information
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

Thank you for choosing Michigan Eye Consultants as your eye care provider. We look forward to providing you with the best eye care in the market!

Spectacles/Contact Lens Prescription Release Policy

This Prescription Release Policy allows Michigan Eye Consultants to email the patient or the patient's representative an electronic copy of the finalized Spectacles and Contact Lens prescriptions when the contact lens prescription is finalized.

I, _____ (please print full legal name), the "Patient" or "Patient's legal representative", have been presented with the Privacy Policy AND the Spectacles/Contact Lens Prescription Release Policy Notices, and have been offered a copy of such policy to keep for my records.

_____	_____	_____
Signature of patient/representative	Name (Pt/Rep)	Date

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Retinal Screening Technologies

Michigan Eye Consultants is a **MEDICAL OPTOMETRY OFFICE** that utilizes top-of-the-line technologies for all of our patients. These high-tech instruments allow your MEC eye care team to detect and treat sight threatening diseases such as glaucoma, macular degeneration, and retinal diseases from diabetes, high blood pressure and high cholesterol. **The earlier we detect these sight threatening diseases, the faster we can manage them.**

Your MEC eye care team HIGHLY recommends both **OPTOMAP AND WELLNESS OCT (Optical Coherence Tomography)** at your annual Eye Health Exam. **OPTOMAP** delivers a 200-degree wide-angle view of your retina **without** dilation. **WELLNESS OCT** allows your MEC Doctor to view the multiple layers of the retina so that we can take a more in-depth analysis of your eye health.

Yes, I accept the fees and would like to have:

_____ OPTOMAP – $45 (HIGHLY recommended for all patients)

_____ WELLNESS OCT – $45 (HIGHLY recommended for all patients with family or personal history of Glaucoma, Macular Degeneration, Diabetes, and High Blood Pressure)

_____ TECH PACKAGE (both high-tech screenings) – $85

_____ I'd like to discuss more with my MEC eye care team

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date

Michigan Eye Consultants

Do you currently or have you ever had any problems in the following areas:

CONSTITUTIONAL		**EARS, NOSE AND THROAT**	
Fever	YES	Allergies / Hay Fever	YES
Weight Gain / Loss	YES	Sinus Congestion	YES
		Dry Throat / Mouth	YES
SKIN ISSUES	YES	Hearing Aids	YES
		Deafness	YES
NEUROLOGICAL			
Headaches	YES	**VASCULAR / CARDIOVASCULAR**	
Migraines	YES	Diabetes	YES
Seizure	YES	Heart Disease	YES
		High Blood Pressure	YES
EYES		High Cholesterol	YES
Loss of Vision	YES		
Blurred Vision	YES	**GASTROINTESTINAL**	
Distorted Vision / Halos	YES	Diarrhea	YES
Double Vision	YES	Constipation	YES
Dryness	YES		
Mucus Discharge	YES	**GENITOURINARY**	
Redness	YES	Gonads / Kidney / Bladder	YES
Itching	YES		
Burning	YES	**BONES / JOINTS / MUSCLE**	
Excess Tearing	YES	Rheumatoid Arthritis	YES
Glare/Light Sensitivity	YES	Muscle Pain	YES
Chronic Infection of Eye(s)	YES	Joint Pain	YES
Styes / Chalazion	YES		
Flashes	YES	**LYMPHATIC / HEMATOLOGICAL**	
Floaters	YES	Anemia	YES
Color Blind	YES	Bleeding Problems	YES

RESPIRATORY		**ENDOCRINE**	
Asthma	YES	Thyroid / Other Glands	YES
Emphysema	YES		
Sleep Apnea	YES	**ALLERGIC / IMMUNOLOGIC**	YES
FAMILY HISTORY			
Blindness	YES	Diabetes	YES
Cataracts	YES	Heart Disease	YES
Glaucoma	YES	High Blood Pressure	YES
Crossed Eyes	YES	High Cholesterol	YES
Macular Degeneration	YES	Kidney Disease	YES
Retinal Problems	YES	Lupus	YES
Arthritis	YES	Thyroid	YES
Cancer	YES		

List any medication you are taking (including oral contraceptives, aspirin, over the counter meds and home remedies). You can also have our eyecare team make a copy of your medication list.

_____

Do you have any allergies to medication or the environment?

_____

List all major injuries, surgeries, and hospitalizations you have had:

_____

Are you pregnant? Yes / No Any present / previous gestational diabetic issues? Yes / No

Do you use tobacco? Yes / No Do you use non-prescription drugs? Yes/No

Would you like your Doctor to evaluate you for contact lenses today? Yes / No

Rate how your contact lenses feel **immediately** after you put them in: Poor / Average / Excellent

Rate how your contact lenses feel **just before** you take them out: Poor / Average / Excellent

_____ _____ _____

Signature of patient/representative Name (Pt/Rep) Date